2025/26 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

SOUTHBRIDGE CARE HOMES
Creating Caring Environments

Queensway Long Term Care Home 100 QUEEN STREET EAST, P.O. BOX 369, Hensall , ON, N0M1X0

AIM		Measure										Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators		Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)																
Access and Flow	Efficient	Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	51211*	21.05	20.00	Increased communication between the families/POA and NP to alternatives that can be provided at the home. Target is based on corporate averages. We aim to do better than or in line with corporate average.			1)Continue to implement regular health screening through IPAC assessments and preventive care measures to help identify	Registered staff to ensure vaccinations are up to date, educate staff on recognizing early warning signs of health issues and provide them with resources in the home to manage both acute and chronic issues.	Number of focused health assessments reviewed per month by the quality lead	100% compliance with focused health assessments completed by registered staff as	
												2)Improve communication between Registered Staff, on site Nurse Practitioner, and Physician by using a consistent communication	Education and re-education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians.	Number of communication process used in the SBAR format, between clinicians per month;	100% of communication between physicians, NP and registered staff will	
												3)IDOC and ADOC to review ED tracker, for the common reasons for transfer to ED - review in Nursing practice meetings, to develop	Utilization internal hospital tracking tool and analyze each transfer status. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings; and standing agenda in nursing practice	Increased SBAR documentation and improved communication within clinical team	50% reduction of ED visits by December 31st 2025.	Utilize Nurse Practitioner, other stake holders such as Medigas, CareRx
Equity	Equitable	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	51211*	100	100.00	This is done annually on our online learning system and is a requirement of employment			1)To increase diversity training through Surge education or live events	Introduce diversity and inclusion as part of the new employee onboarding process	Number of new employee trained of Culture and Diversity	100% of staff educated on topics of Culture and Diversity	
												2)To facilitate ongoing feedback or open door policy with the management team	Celebrate culture and diversity events; educational opportunities	Number of staff education on Culture and Diversity	100% of staff educated on topics of Culture and Diversity	
												3)To include Cultural Diversity as part of CQI meetings	Monthly quality meeting standing agenda- review the number of programs, education completed	Number of CQI meetings with cultural diversity on the meeting agenda and minutes.	100% of CQI meeting minutes will include cultural diversity	
Experience	Patient-centred	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	51211*	54.9	70.00	Increased floor presence and communication from management to residents. Ensuring the DOC has an open door policy.			1)Review of the Whistleblower policy	Review of policy with resident and family with admission and care conferences	Review of policies added to the admission process, care conference	100% of all staff and residents and families will have been made aware of the	
												2)Review "Resident's Bill of Rights" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights #29. "Every	Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting	100% of resident Council meeting will have Residents' Bill of Right #29, added each meeting	100% of all staff and residents and families will have completed the education on	
												3)Review the process for addressing resident and family concerns in the home on admission, during annual care conference and as	Review policy with resident and family on admission and during care conferences	Number of admission packages policy is added too.	100% of admissions and care conferences will review policy.	
Safety	Safe	Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	51211*	14.06	12.00	Increase education to staff on fall prevention methods through quality forums and in house education.			1)Monthly collaboration with Falls committee, and external resources for the development of the resident's plan of care,	To increase training and/or education of Falls program	number of GAP analysis completed related to falls	100% of staff participation on Falls Weekly huddle in each unit	
												2)Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss	Education and re-education provided to registered staff on the completion of post fall anaylsis	Number of environmental and pharmacist referrals	100% of staff participation on Falls Weekly huddle in each unit	
												3)To facilitate a Weekly Fall Huddles	Complete a weekly meeting with unit staff regarding ideas to help prevent risk of falls or injury related to falls	Number of weekly meeting in each unit	100% of staff participation on Falls Weekly huddle in each unit	
		Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	51211*	24	16.00	A review of all residents on antipsychotics on a monthly basis through reports from CareRx and cross reference to ensure there is an appropriate diagnosis.			1)The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly	Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics	Number of referrals to pharmacist for appropriate use of antipsychotics	100% of newly admitted residents will have been reviewed for the appropriateness of	
												2)Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a	BSO lead and nursing team will ensure that residents who receive antipsychotics for responsive expressions with have their medication, plan of care reviewed, quarterly by the interdisciplinary team (including resident and family	Number of residents prescribed antipsychotics medications over the number of residents who have received a medication review in the last quarter.	100% of residents who are prescribed antipsychotic medications will receive a 3 month	
												3)Development of plans of care, with non pharmalogical approach - identification of triggers and interventions	Review of plan of care for non-pharmalogical approaches, in the plan of care	Number of resident who plan of care has been reviewed	100% of full time, nursing staff receive GPA training	
		Percentage of LTC residents who develop worsening pain	C	% / LTC home residents	CIHI CCRS / July 1, 2024- Sept 30 2024 (Q2)	51211*	4.38	4.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.			1)Enhancement of the end of life, palliative care program	Conduct through assessment of the resident, palliative care, end of care. Completion of PPS score, current medication regiment, involve the interdisciplinary team, family and resident with care planning decisions.	Number of staff provided education, Pain management	100% of registered staff to be educated in palliative care.	
												2)Utilization of pain tracker, to monitor the use of prn analgesic	Establish palliative care order set	Number of care plans revised to pain management	Pain tracker current and up to date.	
												3)RAI consultant, to provide education to RAI co-ordinators, on coding requirements for end of life/palliative residents	Utilization of trackers, for prn use, comprehensive pain assessment completed and review of routine analgesic	Number of referrals completed	100% of registered staff will be educated on process.	
		Percentage of LTC residents who develop worsening pressure injury stage 2-4	C	% / LTC home residents	CIHI CCRS / July 1, 2024- Sept 30 2024 (Q2)	51211*	0	0.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.			1)Provide education and re-education on wound care assessment and management. Education provided by NSWOC (during	Arrange education for Registered staff and PSW, with NSWOC	Number of Registered staff and PSW educate	100 % of Registered staff to be educated	
												2)Referral to NSWOC for in home and virtual consults	Develop a list of resident who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices, review of surfaces in place	Number of changes to surface, Number of plans of care updated	100% of resident with PURs 3 or greated, comprehensive assessment	
												3)Monthly review in Quality meeting of resident with Pressure related injuries, review of care plan, progression/lack of healing	Utilization of skin and wound tracking tool, to analysis the pressure related injuries in the home - and the development of plan of care	Number of pressure related injuries which have resolved	100% of resident with stage 3 or greater will have routine assessment completed by	